Brunswick Nephrology & Hypertension, LLC
Tamanna H. Kalra, M.D.
Board Certified: Nephrology
18 Centre Drive, Suite 205
Monroe Twp, NJ 08831
Phone: 732.660.8435 Fax: 732.289.6239
www.brunswickneph.com

New Patient Welcome Packet

Dear _____,

Welcome to Brunswick Nephrology & Hypertension.

We aim to provide compassionate and comprehensive renal care for you. To get started, we ask you to review and fully complete the enclosed patient information packet.

Please be sure to bring all of the items indicated below to your appointment on _____ at _____.

- ☐ The enclosed patient forms fully completed.
- ☐ Any medical records you may have, including blood and urine lab tests, ultrasounds, x-rays, etc.
- ☐ The full names of all physicians currently participating in your health care.
- ☐ All insurance identification cards (to be brought at every visit)
- ☐ A referral, if your insurance plan requires one.

We look forward to being a partner in your health care. Should you have any questions please do not hesitate to contact us.

Sincerely,

Brunswick Nephrology & Hypertension

Brunswick Nephrology & Hypertension, LLC

PATIENT NAME: _____
FIRST NAME MIDDLE NAME LAST NAME

DATE OF BIRTH: _____ SS# _____ SEX: ☐ M ☐ F

STREET ADDRESS _____

CITY: _____ STATE: _____ ZIP: _____

HOME TEL# _____ WORK TEL# _____ CELL TEL# _____

MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W SPOUSE: _____

EMERGENCY CONTACT: _____ RELATION: _____ TEL # _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ POLICY # _____

GROUP # _____ ADDRESS: _____ TEL # _____

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ OTHER

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT): _____

SECONDARY INSURANCE: _____ POLICY # _____

GROUP # _____ ADDRESS: _____ TEL # _____

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ OTHER

POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT): _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

WORK # _____

REFERRING PHYSICIAN: _____

ADDRESS: _____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits directly to Brunswick Nephrology & Hypertension, LLC for all services provided. I request that payment of authorized Medicare benefits be made to Brunswick Nephrology & Hypertension, LLC for services furnished to me by Brunswick Nephrology & Hypertension.

SIGN: _____ DATE: _____

Brunswick Nephrology & Hypertension, LLC

MEDICATION LIST

(INCLUDING OVER THE COUNTER MEDICATIONS)

NAME	DOSE	FREQUENCY

Brunswick Nephrology & Hypertension, LLC

GUIDELINES FOR COMMUNICATION OF PRIVATE INFORMATION

The following will serve to help safeguard the privacy of your medical information in our communications with you.

1. **Contacting me at Home** – phone number: _____
   I give permission to Brunswick Nephrology & Hypertension (BNH), its physicians and employees to contact me at the above number regarding scheduling of appointments. If I am not at home, a message may be left with any adult family member, answering machine or voice mailbox.

   I give permission to BNH, its physicians and employees to contact me at the above phone number regarding any test results and information about my medications. If I am not at home, a message may be left with any adult family member, answering machine or voice mailbox.

2. **Contacting me at any other Location**:
   Phone number: _____
   I give permission to BNH, its physicians and employees to contact me at the above phone number regarding any scheduling of appointments, test results and information about my medications. If I am not available, a message will be left with any adult that answers the phone, an answering machine or voice mailbox. The message will have the physician's or employee's name and a call back number only. No specific information will be communicated with anyone but the patient.

3. **Medical Emergency**
   If my physician considers there to be a medical emergency that requires urgent attention or if I am incapacitated or hospitalized, I give permission for my physician at his/her sole discretion to communicate with any immediate family member to discuss my medical information.

4. **Communication with others**
   Other health care professionals:
   I give permission to BNH, its physicians and employees to communicate by any means including the sharing of office records and test results with any healthcare professionals involved in my care.

   Pharmacy:
   I give permission to BNH, its physicians and employees to communicate by any means with my prescription plan or pharmacy in order to provide information regarding my medications.

   Specific People:
   I give permission to BNH, its physicians and employees to communicate by any means with the following specific people regarding my medical information:
   _____

   Name: (Print) _____

   Signature: _____ Date: _____

Brunswick Nephrology & Hypertension, LLC

PATIENT POLICY AND DOCTOR-PATIENT AGREEMENTS

In order to maintain clear communication with our patients and allow us to completely serve you, the following statement of policy has been prepared. Please review it thoroughly.

1. Each patient must present the current insurance ID card for each policy they have. Brunswick Nephrology & Hypertension (BNH) must be notified immediately of any changes to coverage.

2. A valid referral for the office visit must be obtained prior to your visit. If not done, we will provide you with the opportunity to speak with your primary care physician and obtain one immediately. If a referral cannot be issued at this time, you must reschedule your appointment for when a referral is available. The only other option is to make full payment of your services at the time of your appointment.

3. ***All required co-pays or deductibles are collected at the time of service***. **PLEASE NOTE THAT WE ONLY ACCEPT CASH OR PERSONAL CHECKS.** Medicare patients, who do not have additional coverage, are expected to pay their 20% co-insurance at the time of service.

4. Any checks sent to your home from insurance companies should be brought or sent to our office within three (3) days. Please also send the "Explanation of Benefits" that accompanies the check. This allows us to verify appropriate reimbursement from the insurance plan.

5. The time we have reserved for you with the physician is very valuable. Thus***, you, not the insurance company, will be charged $25.00 NO SHOW FEE*** if you fail to cancel your scheduled appointment by noon of the business day prior to your appointment. The only exception to this is a verifiable emergency.

I have read the above policy statement and understand and accept the policies as stated. I hereby authorize Brunswick Nephrology & Hypertension to release such medical information necessary to process my insurance claims. I hereby authorize payment of my medical benefits to Brunswick Nephrology & Hypertension.

Name: (Print) _____

Signature: _____ Date: _____

HIPAA Notice of Privacy Practices

Brunswick Nephrology & Hypertension, LLC
18 Centre Drive, Suite 205
Monroe Twp, NJ 08831
Tel: 732.660.8435

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEAES REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and organ Donation, Research, Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the user disclosure indicated in the authorization.

HIPAA Notice of Privacy Practices

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us using the information below.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain to us using the contact information below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Tamanna Kalra, MD

Address: 18 Centre Drive
Monroe Twp, NJ 08831

Phone: 732.660.8435

Fax: 732.289.6239

This notice was published and effective on January 01, 2010.

Brunswick Nephrology & Hypertension, LLC

ACKNOWLEDGMENT OF RECEIPT

OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to signing this form, please ask to speak with our staff in person or by phone.

Signature below is only the acknowledgment that you have received this Notice of our Privacy Practices.

Patient Name: (Print) _____

Authorized representative (if applicable): _____

Signature: _____ Date: _____

BRUNSWICK NEPHROLOGY & HYPERTENSION, LLC
18 CENTRE DR., SUITE 205, MONROE TWP, NJ 08831
TEL: 732.660-8435 FAX: 732.289.6239

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO BRUNSWICK NEPHROLOGY & HYPERTENSION

I hereby authorize_____
to release medical records and information pertaining to: *(Please Print)*

Name: _____Date of Birth: _____/_____/_____
(MM) (DD) (YYYY)

Address: _____
Street Address City State Zip Code

Please release to Brunswick Nephrology & Hypertension, LLC by fax at 732-289-6239 or by mail at the address above. Attention: Medical Records.

Purpose or need for disclosure: _____

_____

_____

The information to be released is as follows: _____

_____

_____

I hereby release the records provider from any and all liability whatsoever pertaining to the said use of my records. I understand further that these records, or photocopies thereof, will be delivered physically or by mail or fax to the above name. This authorization is subject to revocation at any time. Without prior revocation, this authorization will automatically expire six (6) months from this date. The party signing authorization has the right to receive a copy of it.

Patient: _____ Date: _____/_____/_____
(MM) (DD) (YYYY)
OR
Legal Representative: _____
If other than patient, basis of legal authority: _____

Witness: _____

This authorization expires on (6 months): _____

Notice to provider of information: Brunswick Nephrology & Hypertension, LLC acknowledges the information requested has been disclosed from records protected by Federal confidentiality rules (42 CFR Part 2). We further acknowledge that the federal rules prohibit us from making any further disclosure to whom it pertains, or as otherwise permitted by 42 CFR Part 2, and that a general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

BRUNSWICK NEPHROLOGY & HYPERTENSION, LLC
18 CENTRE DR., SUITE 205, MONROE TWP, NJ 08831
TEL: 732.660-8435 FAX: 732.289.6239

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, date of birth _____/_____/_____
(Name of Patient) *(MM)* *(DD)* *(YYYY)*
authorize Brunswick Nephrology & Hypertension to furnish to:

Name: _____

Address: _____
Street Address *City* *State* *Zip Code*

The following information (specify type and amount of information requested):

_____

_____

This information is needed for the following purpose(s):

_____

_____

I understand that if my records contain information identifying me as having been tested for HIV infection (HIV having been identified as the virus which causes acquired immune deficiency syndromes (AIDS)) and/or the results of alcohol/drug screening and/or psychiatric or medical records, the results of these tests and such records and information are protected under state law and cannot be disclosed without my written consent or pursuant to a court order.

I have read carefully and understand the above statements and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records (including information identifying me as having been tested for HIV and the results of such tests) to those persons/agencies name above.

I release and hold harmless Brunswick Nephrology & Hypertension, LLC and its agents, officers and employees from any liability whatsoever which may result from the release of this information to such persons/agencies, provided that said release of information is done substantially in accordance with applicable law.

This authorization is subject to revocation at any time except to the extent that the entity which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this authorization will terminate upon 90 days of the date set forth below or (specify event or condition):_____

Patient: _____ Date: _____/_____/_____
OR *(MM)* *(DD)* *(YYYY)*
Legal Representative: _____
Patient is unable to sign because: _____
Witness: _____